CAHs and LTC: Collaborating for Best Practices

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Telligen

Objectives - Decrease Unplanned Transfers!

- Describe the benefits of working with nursing homes
- Collect and report data between the hospital and nursing home
- Apply QI principles and evidence based tools for best practices

Don’t you mean ‘Readmissions’?!

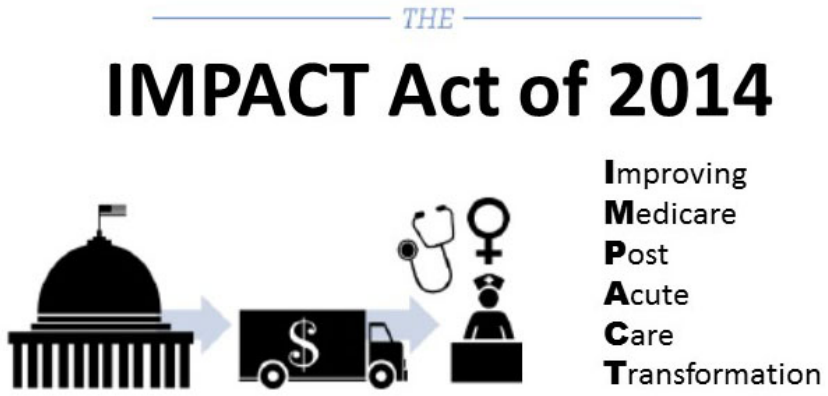
- Hospitalizations
- Unavoidable readmission

We’ll be using ‘unplanned transfer’

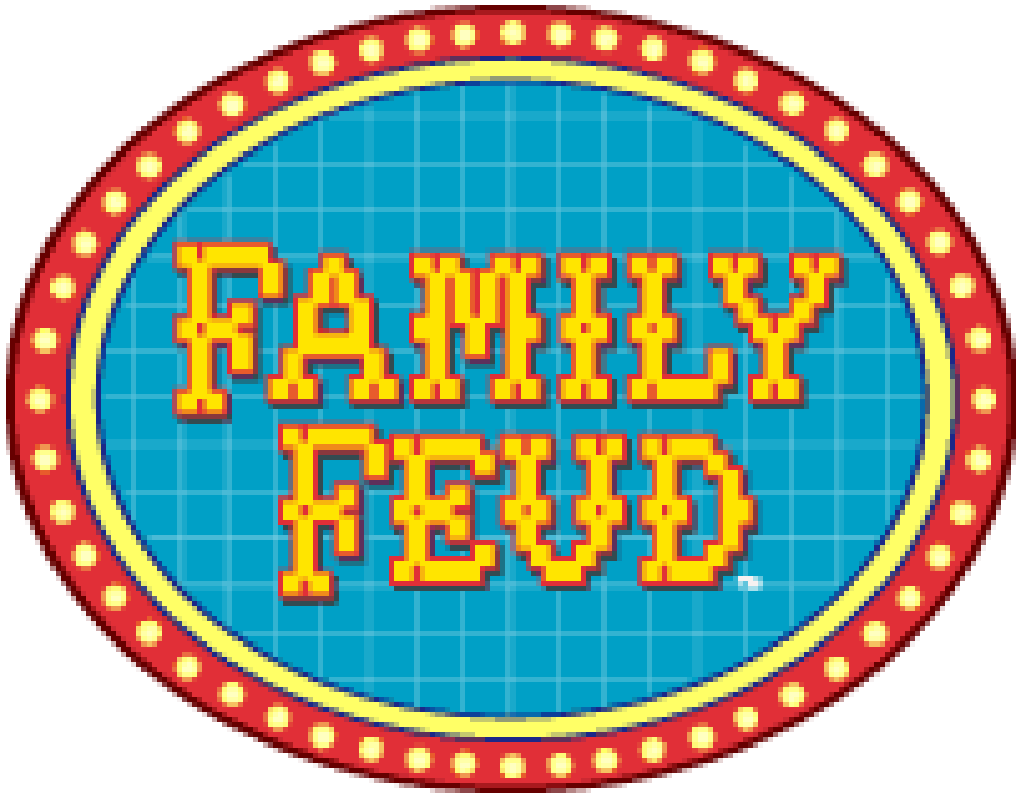
- ‘unavoidable’ is very subjective
- ‘hospitalization’ and ‘readmission’ don’t cover ED or observation

Why does it matter?

- Impact Act of 2014
- New proposed rules for LTC



Survey Says!

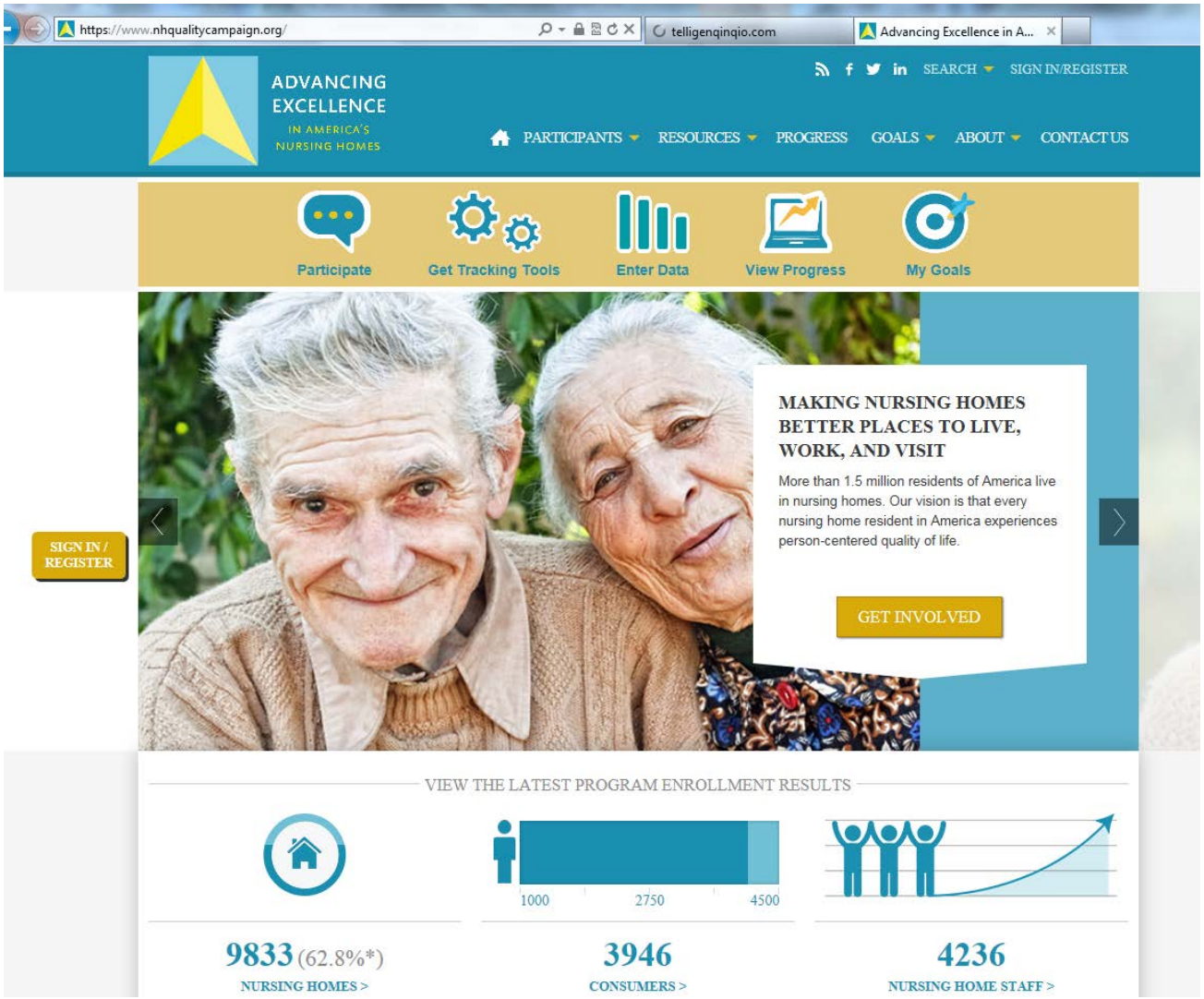


Whose problem is it?

How big is it?

- What's your readmission rate from LTC/ICF?
- What's your readmission rate from Swing bed or skilled?
- What's your ED utilization rate from LTC, ICF or Skilled?
- What's your observation stay rate from LTC, ICF, or Skilled?
- Where do your local facilities send to the most?

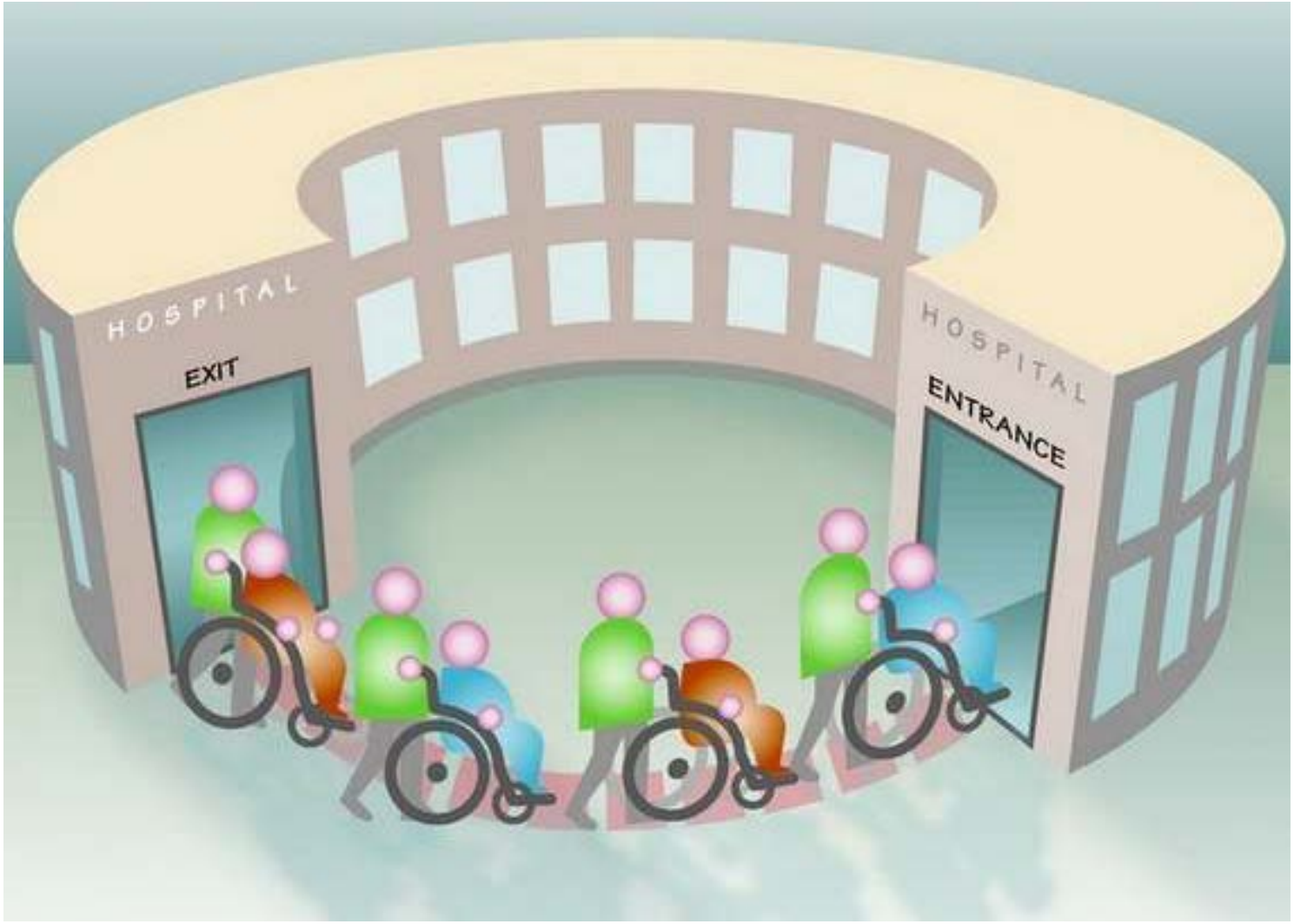
Advancing Excellence



But how?

- What are we offering here?
- What are we suggesting?

Why do people come back?




INTERACT
Interventions to Reduce Acute Care Transfers

The perfect match!

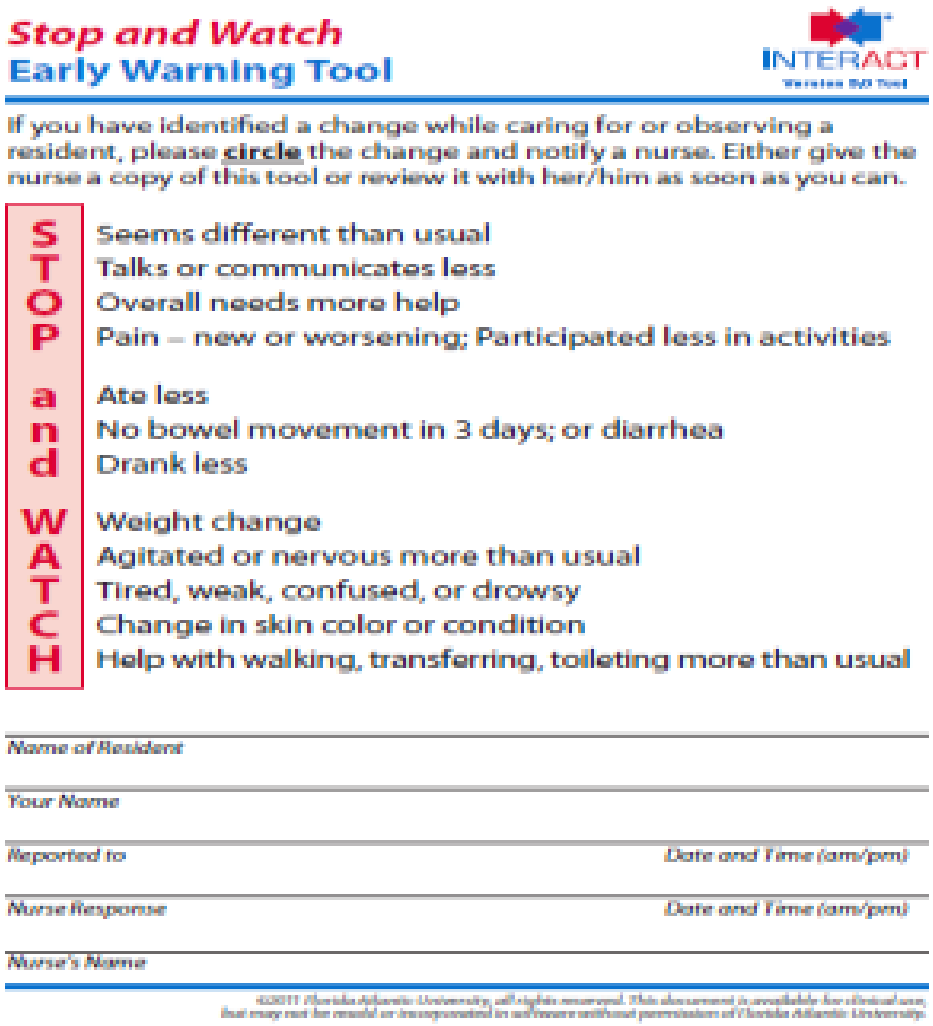
INTERACT
Interventions to Reduce Acute Care Transfers

Top 3 Tools

- Stop and Watch
- SBAR
- Review of Acute Care Transfers

INTERACT
Interventions to Reduce Acute Care Transfers

Stop and Watch



Stop and Watch
Early Warning Tool

INTERACT

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S Seems different than usual
T Talks or communicates less
O Overall needs more help
P Pain – new or worsening; Participated less in activities

a Ate less
n No bowel movement in 3 days; or diarrhea
d Drank less

W Weight change
A Agitated or nervous more than usual
T Tired, weak, confused, or drowsy
C Change in skin color or condition
H Help with walking, transferring, toileting more than usual

Name of Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name

SBAR

SBAR Communication Form
and Progress Note

INTERACT®
Version 3.0 Tool

Before Calling MD / NP / PA:

☐ **Evaluate the Resident:** Complete relevant aspects of the SBAR form below
☐ **Check Vital Signs:** BP, pulse, and/or apical heart rate, temperature, respiratory rate, oximetry, and finger stick glucose, if indicated
☐ **Review Record:** Recent progress notes, labs, orders
☐ **Review an INTERACT Care Path** or **Acute Change in Condition File Card**, if indicated
☐ **Have Relevant Information Available when Reporting**
(i.e. medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

SITUATION

The change in condition, symptoms, or signs I am calling about is/are _____

This started on _____ /_____ /_____ Since this started has it gotten: ☐ Worse ☐ Better ☐ Stayed the same

Things that make the condition or symptom ***worse*** are _____

Things that make the condition or symptom ***better*** are _____

This condition, symptom, or sign has occurred before: ☐ Yes ☐ No

Treatment for last episode *(if applicable)* _____

Other relevant information _____

BACKGROUND

Quality Improvement Tool

For Review of Acute Care Transfers

INTERACT®
Version 3.0 Tool

The INTERACT QI Tool is designed to help you analyze hospital transfers and identify opportunities to reduce transfers that might be preventable. Complete this tool for each or a representative sample of hospital transfers in order to conduct a root cause analysis and identify common reasons for transfers. Examining trends in these data with the INTERACT QI Summary Tool can help you focus educational and care process improvement activities.

SECTION 1: Resident Characteristics and Risk Factors for Hospitalization

Resident ID _____ Age _____

Date of ***most recent*** admission to nursing home _____ /_____ /_____

a. Major diagnoses at admission _____

b. Conditions that put the resident at risk for hospital admission or readmission *(select all that apply)*:

- ☐ Cancer, on active chemo or radiation therapy
- ☐ CHF
- ☐ COPD
- ☐ Dementia
- ☐ Fracture
- ☐ Multiple co-morbidities *(e.g. CHF, COPD and DM in the same patient; or multiple active diagnoses)*
- ☐ Polypharmacy *(e.g. 9 or more medications)*
- ☐ Surgical complications
- ☐ Other *(describe)*

_____

_____

c. Other hospital admissions *(select one)*:

☐ Past 30 days ☐ Past year, but not in the past 30 days *(list dates and reasons below)* ☐ None in past year

_____

_____

d. Emergency Department visits without hospitalization *(select one)*:

☐ Past 30 days ☐ Past year, but not in the past 30 days *(list dates and reasons below)* ☐ None in past year

_____

_____


"Now What?"
It's a question we've been
hearing a lot lately.

Coalition Time!

‘A group of people joined together for a common purpose and action’

Step 1 – Gather your team

- Establish a Steering Committee
  - Those who have a vested interest in the outcome
- Membership
  - Not just health care or related
- Leadership
  - Shared or rotating leadership

Step 2 – Establish a Charter

- Clarifies direction and establish boundaries
- Focus and direction of the team
- Outlines the work and objectives

Step 3 - Meeting

- Meet regularly
- Meet often
- Establish an agenda
- Everyone leaves in action*
- Testing, measurement, and data*
- Send out minutes


Plan
Do
Study
Act

PDSA Worksheet

Achieving your goal will require multiple small tests of change to reach an efficient process and the desired results.

3 Fundamental Questions for Improvement

1. What are we trying to accomplish (AIM)?

2. How will we know that a change is an improvement (MEASURE)?

3. What changes can we make that will lead to improvement (CHANGE)?

Getting Started

- What are we trying to accomplish?
- How will we know a change is an improvement?
- What changes can we make that will lead to improvement?

How does this sound?

- What are we trying to accomplish?
  - Implement and sustain INTERACT in our facilities
- How will we know a change is an improvement?
  - _____# of tools used
  - Decreased # of unplanned transfers
  - Increased # of prevented transfers
- What changes can we make that will lead to improvement?
  - Front line staff as champions
  - PDSA around implementation
  - Measurement

Plan

What is your first (or next) test of change?	Test population?	Due Date

List the tasks needed to set up this test of change:	Who is responsible?	Due Date

Predict what will happen when test is carried out:	Measures to determine whether prediction succeeds:

Plan

What is your first (or next) test of change?	Test population?	Due Date

List the tasks needed to set up this test of change:	Who is responsible?	Due Date

Predict what will happen when test is carried out:	Measures to determine whether prediction succeeds:

Now it’s time for action!

- Where will you do this? By when?
- Who will do what by when?
- What do you think will happen?
- What will you measure?


CHECK IT OUT!

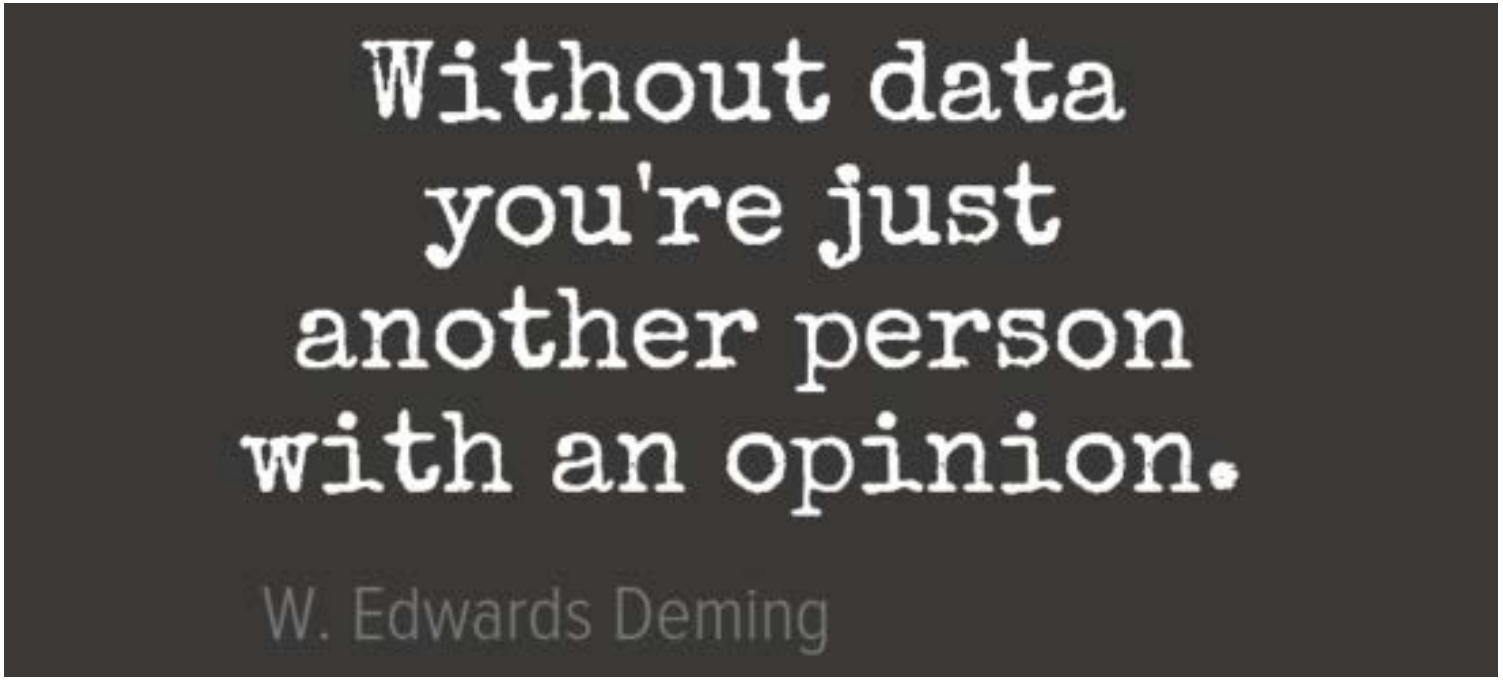
Next steps

- Do
  - Describe what happened when you did the test
  - Any observations, surprises, learnings?
- Study
  - How did your measurement compare with your prediction?
- Act
  - What's next? Will you tweak it and test it again? Will you spread it? (ask someone else to do a small test) Will you repeat your test?

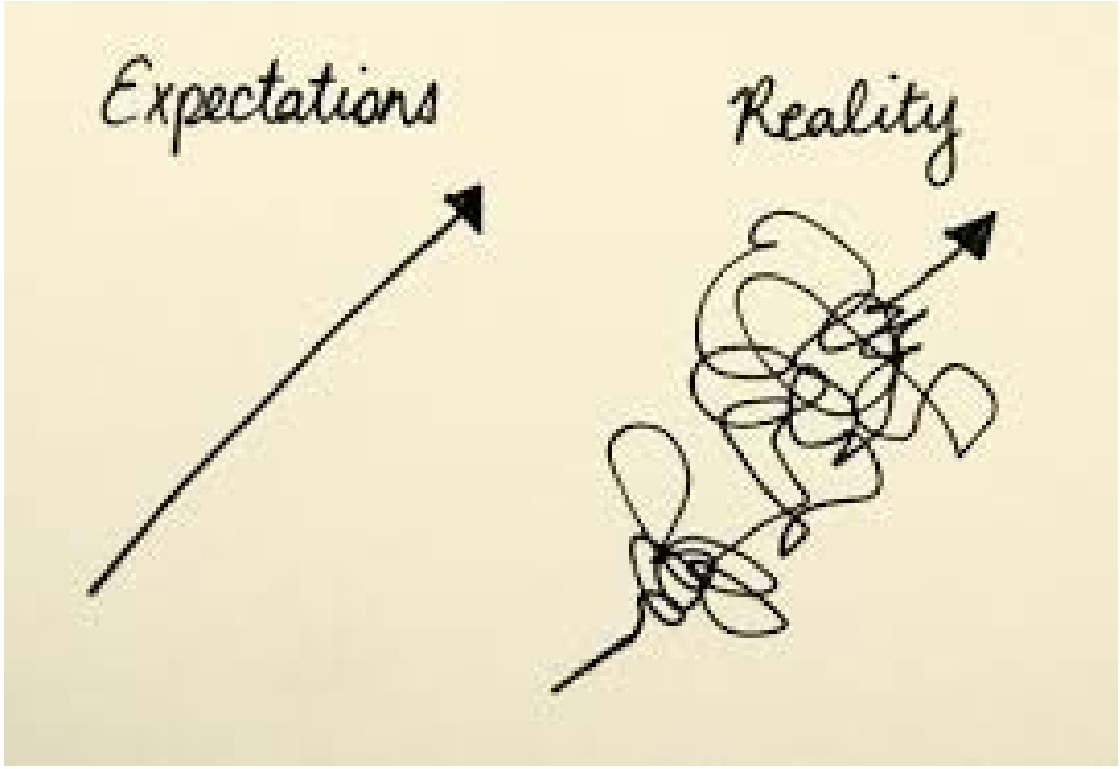
Follow up

- When will you follow up?
- Who will be included?
- What will you do?
- How will you record it?

Data and Measurement



Successful Coalitions



QIO Technical Assistance

- Learning and Action Networks (LAN) on a state-wide level
- Webinars provided and recorded
- Connect to downstream providers
- Provide current Medicare data to providers

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